



# Types of Homes and Levels of Care

## **SKILLED NURSING FACILITIES (SNFS)**

A Skilled Nursing Facility is a nursing home that provides 24-hour per day skilled nursing care and related services, or rehabilitative services for the injured, disabled, or sick persons. Medicare pays for residents with Medicare insurance for care only in a SNF certified facility. Medicaid will pay for eligible residents in a certified Nursing Facility (NF).

To illustrate, skilled care provides:

- supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis.
- 24-hour patient care including medical, nursing, dietary, pharmaceutical services and an activity program.
- emphasis on rehabilitation, such as gait training, and bowel and bladder training.
- higher patient/staff ratio.
- administration of potent and dangerous injectable medications and intravenous medications and solutions on a regular basis.

Cancer, fractures, and cardio-vascular accidents are examples of conditions residents might have.

As of 2000, there were 670 Nursing Facilities with a total availability of 118,000 beds.

## **ADULT CARE FACILITIES (ACF)**

New York State's Department of Health, specifically the Office of Housing and Adult Services' Bureau of Continuing Care, supervises most adult



care facilities which are providing temporary or long term, non-medical residential care services to adults who are unable to live independently. Resident dependence may be the result of physical or other limitations associated with age, physical or mental disabilities or other factors. Most residents of adult care facilities are in need of supervision, as well as personal care services. Personal care services include such Activities of Daily Living (ADLs) as grooming (hair and nails, teeth and mouth), dressing, bathing, walking, eating, toileting, transferring to and from bed and chair, and assisting with the self-administration of medications. Adult care facilities are not licensed to provide on-going nursing or medical care. These facilities include:

- *Adult Homes* which provide long term residential care, room, board, housekeeping, personal care and supervision to five or more adults unrelated to the owner (operator). Ownership may be proprietary (profit making), public or not-for-profit. In 2000, there were 460 Adult Care Facilities with a total of 34,000 beds.
- *Assisted Living Programs* are located in the Adult Home facilities which are also licensed personal care services providers. The program has been designed as an interim between Adult Home and Nursing Facility Placement. Residents have needs which are primarily social, rather than medical, but require limited medical services, usually of a home health aide level. In 2000, there were 4400 approved beds, of which only 1900 were occupied.
- *Enriched Housing Programs* provide long term residential care to five or more adults primarily 65 years of age, or older, in community-integrated settings resembling independent housing units. The program arranges for the provision of room, board, housekeeping, personal care, case management and supervision. These programs may be operated only by public or not-for-profit sponsoring agencies. In 2000, there were 52 programs with 1200 residents participating.





## BOARD AND CARE FACILITIES

New York State's Office of Children and Family Services and local departments of social services license and supervise Board and Care Facilities such as:



- *Family Type Homes* which provide long term residential care, room, board, housekeeping, personal care and supervision to four or fewer adults unrelated to the operator. The operator provides the services in his or her own home. Neither proprietary or not-for-profit corporations are permitted to operate family-type homes.
- *Homeless Shelters* for adults and families with children who have been unable to obtain suitable shelter.



# Ownership and Management of Nursing Homes

Ownership and management of long term care facilities is carried out by a variety of providers with an almost endless array of administrative and financial arrangements.

## PROPRIETARY OWNERSHIP

When a facility's income (or revenue) exceeds its expenses, it earns what is commonly called a profit. Proprietary nursing homes are in business to produce profits. Profits are either given to the owner(s) of a home or are reinvested in the business.

There are two basic forms of proprietary ownership:

- *Individual or partnership:* Profits are funneled to individual owners or partners who are personally liable for a business' operation and debts and can be sued as individuals.
- *Corporate:* Corporate stockholders or members are not individually liable for the corporation and cannot be sued for its actions or debts. In New York State, while so-called "chain" operations exist, unlike some states, they may not be subject to financing through public stock options.

## Non-Profit Ownership

Non-profit nursing homes also produce profits, but these may not be legally distributed to individuals or groups for personal use. Instead, profits are returned to the general coffers of the organization. The primary financial goal of non-profit facilities is to maintain revenues sufficient to cover their costs and have enough surplus to expand services as needed. Many non-profit homes are sponsored by religious or charitable institutions.





## **Government Ownership**

Other nursing homes are government-operated. Such homes are administered by county, state or federal governments. Government facilities' costs tend to be higher than those of non-profit facilities. Veterans' nursing homes are included in this category. <sup>1</sup>



# Staff and Departments of Long Term Care Facilities

The staff in a long term care facility are assigned to various departments, e.g., nursing, housekeeping, dietary, etc. Each department is responsible for contributing to the overall functioning of the facility. The size and composition of departments of each facility are contingent upon its total size and the level of care provided. Therefore, there may be differences between two long term care centers. However, in an attempt to become familiar with the structure of a “typical” nursing home, examples of departmental responsibilities and staff include:

## DIETARY DEPARTMENT

The dietary program is responsible for planning and preparing the food served in a nursing home in accordance with state licensure regulations (and federal certification requirements if it is a certified facility). Some nursing homes have a menu cycle, such as a four-week cycle or a seasonal cycle. Special diets must be ordered by a physician. Any food brought to a resident by friends or family should be brought to the attention of the nurse in charge to assure it will not interfere with the effectiveness of a prescribed diet.

Examples of dietary staff:

- *Dietician*: expert in planning menus, diets and dietary procedures. The dietician is responsible for setting up special diets, as well as maintaining proper nutritional levels for residents.
- *Food Services Supervisor*: is responsible for the daily preparation of foods, special diets, etc. He uses the menus developed by the dietician.





## ACTIVITIES DEPARTMENT

Most nursing homes have an activities program. An activities program is a requirement for certification of ICFs and SNFs. Activities should be planned to be appropriate to the needs and interests of the residents and to enhance the quality of life.

Examples of activity staff:

- *Recreational Therapist* (also called *Activities Coordinator* or *Activities Director*): responsible for developing, scheduling and conducting programs to meet the social and diversion needs of residents.

## NURSING SERVICES

The nursing services section generally includes RNs, LPNs, and CNAs. These are the people who provide direct care to the residents.

Examples of the nursing staff:

- *Director of Nursing (DON)*: a registered nurse (RN) who oversees the entire nursing staff, including nursing supervisors, licensed practical nurses, aides and orderlies. The DON is responsible for quality and safety in patient care.
- *Nursing Supervisor* (also called *Charge Nurses*): responsible for nursing (resident) care on a floor, or in an area or section, or the nursing home during a particular shift. May be an RN or LPN.
- *Licensed Nurse (LPN)*: a person who has completed one year vocational training in nursing. May be in charge of nursing in the absence of an RN. LPN's often administer medications and perform treatments.
- *Certified Nursing Assistant (CNA)*: CNAs supply 80-90% of the "hands-on" patient care given in nursing homes. Within four months of employment by a nursing facility or skilled nursing facility, CNAs are required to complete a training and competency evaluation program approved by the state, and be competent to



provide nursing and nursing related services. For more information see SDoH regulations 10 NYCRR S.415.26.

## ADMINISTRATION

The administrative unit of a home may include the nursing home administrator, secretarial staff, accounting, and admissions.

- *Nursing Home Administrator*: responsible for overall (fiscal, legal, medical and social) management and operation of the facility. This individual is ultimately responsible for all nursing home activities.
- *Medical Director*: the physician who formulates and directs overall policy for medical care in the nursing home. Usually only a part-time position.

## SOCIAL SERVICES



Social Services departments are responsible for identifying the medically-related and emotional needs of the patient. An assessment of each resident's needs should be found in her record and needed services



should be incorporated into the care plan. OBRA 1987 requires every nursing facility with more than 120 beds to employ a full-time professional social worker.

Examples of Social Services staff:

- *Social worker*: person trained to identify medically-related and emotional needs of residents and provide services necessary to meet such needs.

## HOUSEKEEPING AND LAUNDRY

Members of the housekeeping staff are usually responsible for basic housekeeping chores such as sweeping floors, dusting, emptying waste cans, and cleaning furnishings.







Every nursing home has laundry facilities and is responsible for providing clean bed linens and towels. The home is also equipped to launder resident clothing.

## **MEDICAL STAFF**

Medical staff are responsible for attending to the physical needs of the residents. Nursing is the most obvious medical department. A variety of other health care personnel are part of the staffing.

Examples of these positions are:

- *Attending Physicians*: directly responsible for the care of resident. Each resident must either choose his own physician or have one assigned by the nursing home to supervise his care.
- *Podiatrist*: specializes in the diagnosis and treatment of diseases, defects and injuries of the foot.
- *Dermatologist*: specializes in the diagnosis and treatment of diseases, defects, and injuries of the skin.
- *Ophthalmologist*: specializes in the diagnosis and treatment of diseases, defects and injuries of the eye.
- *Physical/Rehab Therapist (PT)*: trained in restoring the function of muscles in arms, legs, backs, hands, feet, etc., through movement, exercises or treatment. Usually a consultant to the facility. Sometimes physical therapy assistants carry out the plans of the therapist.
- *Occupational Therapist (OT)*: a person trained to conduct therapy to restore the fine muscles of the hands and arms.<sup>2</sup>

It is important that the Ombudsman request to see the organizational chart of the home in order to understand the administrative lines of authority, responsibility and supervision. This will enable you to identify the appropriate persons when you need information from staff at a particular institution.<sup>3</sup>



# Programming

Just as staffing patterns are different, programs offered in a facility will vary from place to place depending upon the type of residents served, availability of personnel and the amount of income that the home can generate. The locale of the facility also influences the type of personnel available in a given community. The more common programs include the following:

- *Remotivation*: A method of planned interaction between staff and residents used to increase social interaction and to stimulate interest in the outside world.
- *Activities*: An umbrella term that includes crafts, art work, social gatherings, discussion groups, outside events, many forms of recreational and sometimes intellectual activities. While nursing home volunteers perform many functions, they are most commonly active in this department and program.
- *Exercise*: Group or individual exercise program to maintain or improve muscle function, increase circulation and enhance a sense of well-being.
- *Work*: A plan for residents who wish to earn a modest amount of money in order to maintain their need to feel useful through work.
- *Music and Drama*: Opportunities for self-expression, therapy and/or fun can be achieved through music and drama.
- *Grief Therapy*: Group discussions (usually led by a nurse therapist or social worker) designed to assist residents in expressing unresolved grief in order to release energies for more satisfying activities.
- *Resident's Council*: A formal group of residents committed to expressing the needs and desires of residents to staff. For residents, it provides a tool to exercise some role in decision-making, an op-





portunity to ventilate feelings, an information forum, a vehicle for communicating to staff and a sense of group support. For the staff, it provides a means for gathering resident input, a method of clarifying roles and responsibilities within the home, help in program policy planning, promotion of more orderly problem resolution in many instances, and greater awareness of resident problems by staff. <sup>4</sup>



# Long Term Care Residents

## ENTRY INTO LONG TERM CARE

How do elderly individuals end up entering long term care settings? Generally, there is a gradual progression of losses, diminution of strengths, decreasing opportunities for meaningful and restorative personal and social experiences, and increased isolation. As self-sufficiency decreases, there is less opportunity for continued living in the community. Communities often do not have adequate services to replace and provide those supports and opportunities which once came from the family and the neighborhood. Generally, the family, the community agency or a hospital (through the physician and social workers) step in and decide that the older people can no longer adequately care for themselves or be cared for in the community. When a long term care institution or nursing home is chosen as an alternative, it is usually the only option.

The transition that the elderly (and their families) face when the elderly individual moves from a community setting to an institutional setting is a difficult one. Many of the problems (e.g., physical disabilities or deterioration) do not start with entry into the long term care setting, but must be dealt with there. Other problems facing the new resident arise because of the nature of the setting itself and how services are delivered within an institutional setting.

## POPULATIONS IN LONG TERM CARE FACILITIES

### Older Residents

It is a myth that most elderly people live in nursing homes. Some statistics about nursing home residency can tell a clearer story. According to the AARP publication, Mid-Life and Older Americans with Disabilities, only about four percent (4%) of the elderly population, in the United States, are in nursing homes at any given time, although one in four will need





long term care assistance during their later years. In 1995, there were 1.5 million people (of all ages) living in nursing facilities (16,700). An estimated two percent (295,000) of those aged 65 to 74 years were in a nursing home compared to about seven percent (627,000) of persons aged 75 to 84 years, and about 16 percent (489,000) of persons 85 and over. The rate of nursing homes used by the elderly has increase significantly since the introduction of Medicare and Medicaid in 1966, from 2.5 to 4 percent of the over-65 age group in 1996.

A majority, 83%, of nursing home residents are without a spouse, as compared to just over 40 percent of the non-institutionalized elderly. Such statistics, along with those which show that nursing home residents tend to have health problems which significantly restrict their ability to care for themselves, suggest that the absence of a spouse or other family members who can provide informal support for health and maintenance requirements is the most critical factor in the institutionalization of an older person. In analyzing the characteristics of nursing home residents, a profile of the “typical” resident can be compiled from the following statistics:

- They are generally very old. 75% of nursing home residents are 75 years and older.
- They are generally female. 72% of nursing home residents are women.
- Most are single. Only 17% of nursing home residents have a living spouse.
- Many suffer from behavioral or mental problems. Studies have shown that many nursing home residents suffer from mental disorders. While most of these residents have some form of dementia, no one knows the percentage of residents who have reversible dementia that could be treated.
- Most have chronic or crippling disabilities and need help with the Activities of Daily Living, specifically bathing (96%), dressing (87%), toileting (58%), eating (45%) and transferring (24%).<sup>5</sup>

## AIDS Population

Estimates are that there are currently 1 to 1.5 million persons infected with the HIV virus of which the AIDS disease is one manifestation. Of those who die of AIDS, estimates are that 13% are 55 years and older. As a disease it is more prevalent in the younger ages and not as prevalent in the traditional nursing home resident. Of those who die of AIDS, 6% live in some type of institution such as prisons, mental hospitals or nursing homes. When examining data about residency in nursing homes, the number was too low to yield reliable estimates. This shows that AIDS patients are not prevalent among the nursing home population. Still, nursing homes are an appropriate setting when such care is needed.



It is a violation of Section 504 of the Federal Rehabilitation Act to discriminate against someone based on disability. Since the AIDS disease is



twice as prevalent among Blacks and Hispanics, discrimination against these populations violates Title VI of the Federal Civil Rights Act. Also,



Article 27-F of the Public Health Law has strict requirements regarding confidentiality to AIDS patients receiving health-related services. These laws apply to all facilities that accept Medicare, Medicaid or those financed through the Hill-Burton program. While Ombudsmen are not subject to the law directly, they must be aware of the sensitive confidentiality protections awarded to this population. Specifically; "Confidential HIV related information' means any information, in the possession of a person who provides one or more health or social services or who obtains the information pursuant to a release of confidential HIV related information, concerning whether an individual has been the subject of an HIV related test, or has an HIV infection, HIV related illness or AIDS, or information which identifies or reasonably could identify an individual as having one or more of such conditions, including information pertaining to such individual's contacts." The purpose of this law is to ensure against discrimination.





## **Mentally Retarded/Developmentally Disabled and Mentally Ill Populations**

Persons diagnosed as *Mentally Retarded/Developmentally Disabled (MR/DD)* meet the following definitions:

“Developmental disabilities” means the disability which is attributable to: (a) mental retardation, cerebral palsy, epilepsy or autism; or to (b) any other condition which results in impairment similar to that caused by mental retardation which requires services similar to those required by mentally retarded persons. Such disability must originate before the age of 18 years, be expected to continue indefinitely, and constitute a substantial handicap.

“Mental retardation” means significantly subaverage general intellectual functioning which exists concurrently with impairment in adaptive behavior and which originates before the age of 18 years.

The MR/DD population can reside in Adult Care Facilities. There are also MR/DD persons in “geriatric” nursing homes. Most of these residents are younger people, but some are older. Many were placed in “geriatric” homes as the result of deinstitutionalization efforts that ended reliance on large warehouse-type institutions as the primary place for treatment. The MR/DD population came to reside in “geriatric” nursing homes for one of the following reasons:

- No ICF-DD or other appropriate bed was available for the person in the community or close to their home;
- Individual had medical needs and needed care in a nursing home; or
- Individual was perceived as “old” and there was a presumed need for nursing home care.

Because active treatment is not required in adult care facilities or skilled nursing facilities, “geriatric” MR homes may not be an appropriate setting.

The Mentally Ill Population (MI) generally refers to psychoses like schizophrenia and affective disorders like bi-polar (manic-depression) personalities. These are serious diseases and need to be distinguished from situational depressions that result from grief or a loss. Many mental illnesses are treatable and reversible but some, like schizophrenia, can last a lifetime and need continued treatment. Some nursing homes have younger mentally ill residents for much the same reasons there may be MR/DD persons residing in homes. In addition, older persons who require nursing home care can develop serious mental illness for which they need treatment.

States are required to screen new admissions and current residents to decide if there is a more appropriate setting that can meet the needs of the MR/DD and MI populations. This review system is completed using the SCREEN.

## **ADJUSTMENTS TO INSTITUTIONALIZATION**

The move from community to a long term care setting is a major life event for both resident and family. As a professional working with an institutional system, it is important to remember and evaluate the stress in adjusting to a new setting.

### **Residents**

Some residents in long term care facilities may have difficulty adjusting to life in an institution. A move from the community to an institution often means many changes in lifestyle, including: set routines for meals and for getting up and going to bed; a decrease in contact with the community; more free time with structured activities available only at certain times; decreased privacy and independence; fewer opportunities for decision-making; loss of home and many possessions and links to the past; increased loneliness; and the need to adjust to staff and other residents.

Normal reactions to these changes include anger, depression, grief, confusion, and withdrawal. Some residents have difficulty adjusting to the







facility, and their new lifestyle. Residents should be encouraged to state their opinions and preferences, and should feel free to voice any concerns they might have. Many persons are eventually able to make a successful adjustment to institutional living. Persons who live to old age have weathered many changes throughout their lives, and are often more resilient and capable of adjusting to loss than are younger adults, simply because of their past experiences.

Although physical needs may be more than adequately met in an institutional setting, the older people's belief in themselves as worthwhile individuals may be somewhat threatened. It is important that psychological needs be met including:

- The need to be seen by others as an adult who has had a lifetime of experience.
- The need to have others recognize one's uniqueness.
- The need for respect and approval from others.
- The need for self-confidence.
- The need for positive interaction with others.
- The need to preserve one's sense of identity.
- The need for emotional support.
- The need for as much control as possible over one's environment.

Being a resident of a long term care facility does not mean one surrenders all his rights. It also does not mean one becomes totally dependent upon others for care. Staff may inadvertently encourage dependency because it is easier and faster for them to care for the residents, than to allow time for the residents to do things for themselves. The residents who, because of the move to an institution, doubt their self-worth, may give up trying to do anything independently. This "learned helplessness" is a condition in which individuals believe that nothing they do matters, and therefore, they make no effort to control their environment. Learned helplessness

may be discouraged when residents are given the opportunity to make choices and are encouraged to do things for themselves. Studies have shown that nursing home residents' life satisfaction improved when they were given the chance to make more decisions.<sup>6</sup> These do not have to be major decisions either. Little things like choosing their own outfits or deserts can vastly improve the adjustment to the facility.

## Family

The family also must make adjustments to a member living in a long term care facility. Usually the placement of a relative in a nursing home leaves the family with a mixture of feelings. They are likely to feel relief that the ordeal of selecting and choosing a nursing home is over, that the emotional storm raging around whether or not to put the relative in the nursing home has finally been resolved.

But in addition to relief, feelings of guilt may also play a major part in how the family reacts to the resident and the nursing home situation. No family enjoys having to place their relative in an "institution," no matter how nice a place it may seem to be. The family usually feels as if it could have prevented the situation from going as far as it did, either with the deterioration of the resident's physical condition, or the emotional strains that were placed on everyone involved. As individuals, they may feel self-accusatory, blaming themselves and each other for not doing "more" to help cushion the effects of aging, or take (or keep) their parents at home with them. The sense of helplessness which underlies the family's inability to cope with the needs of the aging will have become pervasive by the time the relative has reached the nursing home.

Expressions of family guilt may be acted out in a number of ways--possibly in the way the family speaks to the resident, in an angry, babyish, or child-like manner; in the insistent demands it makes on the nursing home staff; or in staying away from relatives altogether.

When relating to residents' families, Ombudsmen should be aware of the following factors:





- When relatives “complain,” they may often be more upset with themselves than with nursing home personnel.
- Many relatives feel guilty that they were unable to care for the resident themselves, perhaps due to physical reasons (size of home) or psychological reasons (unable to tolerate a sick and dependent parent) and have had to allow someone else to assume “their” responsibility.




# Long Term Care Reimbursement

Who pays for long term care? The increasing number of very old and frail persons, the rising costs of health care, and the availability of fewer family members to provide home care combine to make this question a major national concern.

While any long term care reimbursement scheme must ultimately include adult day care, home health, and other non-institutional services, the focus of this discussion is on who pays for nursing home care.


The vast majority of persons you encounter in nursing homes will be on Medicaid. Other sources of payment will include private pay, Medicare, Veterans Administration, and in a few cases private long term care insurance.


## MEDICAID

 Medicaid is a medical assistance program for low-income persons. It was established by Title XIX of the Social Security Act of 1965 and is often referred to as "TITLE XIX." It is a joint Federal-State program which reimburses providers for covered services to eligible persons.



 The Department of Health and Human Services (HHS) administers the program through the Center for Medicare and Medicaid Services (CMS).

 CMS establishes general guidelines and monitors operation of the program by the states. Both state and Federal funds are used in the program, based on a percentage determined by each state's per capita income. States are given some flexibility in deciding what services are covered and who is eligible, so there are differences in Medicaid from state to state.

 Up-to-date figures are always available from your HIICAP Unit or your local department of Social Services to determine who is eligible.





### *How Payment is Determined*

Even though eligible for Medicaid, a resident must still pay most of her income to the nursing home. Medicaid allows a resident to keep enough for specific needs, called a personal needs allowance (PNA) and the remainder goes to the facility. The Medicaid program then pays the difference.

### *Spousal Impoverishment*

The Medicare Catastrophic Coverage Act of 1988 changed the amount of income that the spouse of a Medicaid covered nursing home resident could retain.

### *Covered Services*

Certain services are required for nursing homes and are included in the payment made to the home. All services must be certified as medically necessary.

## **MEDICARE**

Medicare is actually two programs: Part A covers hospital and related care; and Part B, which covers physicians and other medical expenses. It was established by Title XVIII of the Social Security Act and is sometimes referred to as "Title XVIII." Medicare, like Medicaid, is administered by a number of agencies. The Social Security Administration handles eligibility determinations. The Center for Medicare and Medicaid Services (CMS) governs administration of the programs, and private insurance companies under contract with the government handle actual claims and payments.



### **Part A**

*Covers hospitalization and related costs for skilled nursing, hospice, and home health following a hospital stay.*

*Persons 65 or older who have paid Social Security or Railroad Retirement are eligible automatically. No premiums.*

## **Part B**

*Covers cost of physician services and related medical supplies, tests and services.*

*Persons covered under Part A are deemed enrolled in Part B, unless they decline. Others can enroll. Everyone pays a premium, which is usually deducted from their Social Security check.*

### *Part A*

Contrary to what many elderly people believe, Medicare covers very little nursing home care. Medicare only pays for a maximum of 100 days, if certain criteria are met, in a skilled nursing facility. These days must be preceded by a hospitalization of at least three days. The first 20 days are paid in full. Thereafter, the beneficiary must pay a co-payment. A beneficiary has the right to appeal the denial of skilled care Medicare.

You may deal indirectly with Medicare when assisting a person admitted to the nursing home from a hospital.

### *Part B*

Part B of Medicare is a bit like a major medical insurance policy. It covers the cost of physician services, related medical services, test and supplies, etc. As with Part A, there are deductibles and co-payments. You are more likely to get questions about Part B because most residents are “skilled” and because Part B will pick up certain items or services regardless of primary payor. It pays for certain items or services for nursing home residents whose facility fee is paid by Medicaid. For example, physical therapy can be billed to Part B for both private pay and Medicaid residents.

Part B payments are based on an allowable charge (also called reasonable or approved charge). This is the amount set by the part B carrier for a specific service. The charges are based on a review of doctors and suppliers’ actual charges in an area during the previous year. Part B pays 80 percent of the allowable charge. By law, the allowable charge must be the low-





est of: (1) the actual charge; (2) the customary charge (the middle charge made by each provider for the service) or (3) the prevailing charge (an amount high enough to cover the customary in three out of four bills).

A term you will hear frequently when dealing with Part B is *assignment*. If a provider does not agree to accept Medicare's allowable charge as payment in full, it is called a non-assigned claim. The beneficiary is responsible for any excess amount over the allowable charge, plus the 20 percent co-payment. With non-assigned claims, either the beneficiary or provider submits the claim to the Part B carrier. The carrier sends a check to the beneficiary, along with an explanation of benefits form.

If the provider agrees to accept the allowable charge as payment in full, he is "accepting assignment." Part B pays 80 percent of the allowable charge, but the beneficiary is responsible only for the 20 percent co-payment. The beneficiary is not responsible for any excess charges. The provider submits the claim directly to the carrier and the carrier pays the provider.

## **Appeals**

Very few Part B beneficiaries appeal decisions. When they do, however, more than half win. An appeal may be appropriate if a claim is denied or less is paid than expected, or if one feels errors were made or information was overlooked. Appeals can be made to the carrier by making a written request for review. If the carrier's decision is unfavorable, a formal hearing can be requested.

## Medicare Part A Benefits

Coverage is based on a benefit period. This period begins on the first day a beneficiary receives inpatient hospital care and ends after she has been out of a hospital or skilled nursing facility for a maximum of 100 days.

### Coverage Per Benefit Period

### Beneficiary co-payment

#### Inpatient Hospital Services

\$\_\_\_\_\_ deductible per spell of illness

First 60 days

none

61st - 90th day

\$\_\_\_\_\_ per day

60 Lifetime Reserve Days

\$\_\_\_\_\_ per day

*(check with your local Medicare Office  
for current coverage and co-payments)*

#### Skilled Nursing Facility

*(Must be certified as needing skilled care  
by physician and hospitalized for three  
days within the 30 days prior to using  
the skilled benefit)*

First 20 days

none

21st - 100th day

\$\_\_\_\_\_ per day

#### Home Health Care

*(Provided to homebound persons in  
need of part-time, skilled nursing care or  
therapy services)*

21 consecutive days

none

*Hospice Care (Paid for in lieu of  
standard Medicare benefits for terminally  
ill at beneficiary's choice.)*

\_\_\_\_\_% of cost of outpatient drugs  
or \$\_\_\_\_ per Rx. \_\_\_\_% of cost of  
inpatient respite care







## Medicare Part B Coverage

### Coverage Per Benefit Period

Doctor Services provided by:

- Doctors of Medicaid and Osteopathy
- Dentists performing dental surgery or setting certain fractures
- Podiatrists (excluding routine foot care)
- Chiropractors for treatment involving manual manipulation of the spine to correct a subluxation
- Optometrists for treatment of aphakia

*Covered services may be provided in a Dr.'s office, hospital, SNF, or in the home*

### Beneficiary co-payment

The beneficiary pays:

1. \$\_\_\_\_\_ \* per year deductible
2. Coinsurance of \_\_\_% of "reasonable charge"
3. Any amounts in excess of reasonable charge.

#### *Exceptions*

1. Inpatient radiology or pathology; no deductible or coinsurance
2. Home health; no coinsurance
3. Blood; no coverage for first three pints

## Other Medical and Health Services

- Diagnostic X-ray and lab tests
- Outpatient hospital services
- X-ray and other radiation therapy
- Services and supplies furnished in connection with physician's services
- Surgical dressings, splint, casts
- Durable medical equipment (whether rented or bought)
- Artificial devices that replace all or part of an internal organ
- Ambulance services
- Braces and artificial limbs and eyes
- Physical, speech, occupational, and respiratory therapy

## Home Health

If homebound and need part-time skilled care or therapy—covers home health aides, etc.

## VETERANS ADMINISTRATION

*Veterans Administration (VA) Paid Community Nursing Home Care Program:*  
The VA-Paid Community Nursing Home Care Program is a plan under



which the VA will pay for up to six months of skilled/intermediate nursing home care following hospitalization for those veterans who qualify.

### *Who is Eligible*

Hospitalized veterans who no longer require hospital treatment are eligible. In general, in order to take part in the program, the veteran must not have sufficient funds to meet the cost of this care himself. The nursing homes which are under contract with the VA to participate in this program agree to provide full nursing home care, including medicine and drugs, for a daily rate approved by the VA.

### *Nursing Home Care After 6 Months*

If the veteran continues to require skilled/intermediate nursing home care, the veteran may remain in the nursing home for an additional period of time at the veteran's own expense. If the veteran does not have sufficient funds and is not eligible under Medicare, the state Medicaid program may be able to supplement the cost of nursing home care.

### *What Happens if a Nursing Home Resident Needs Hospitalization?*

If the veteran requires hospitalization during the period of nursing home care authorized at VA expense, she may be returned to the VA Medical Center upon the recommendation of the nursing home physician. If the veteran's hospital stay is a relatively brief one, the veteran may be returned to the nursing home to continue to receive care for the remainder of the original placement agreement.

### *What Happens to a Veteran's Pension when placed in a Nursing Home at VA Expense?*

In general, veterans without dependents will have their pensions reduced during the period of nursing home care at VA expense. There will be no reduction in the basic pension paid to veterans with dependents. Benefits paid in addition to the basic pension (for example: Aid and Attendance) will be reduced during the period of skilled/intermediate nursing home care.





## LONG TERM CARE INSURANCE

You may encounter a resident who has private long term care insurance. As the demand for long term care services increases, insurance companies have begun to develop products which provide coverage for nursing home and or home health care. These policies are expected to account for an increasing percentage of long term care financing, although most experts agree that they will never represent a major source of payment.

Most policies available are a form of “indemnity” policy, meaning they pay a set amount per day, week or month for care. There are tremendous variations in policies as to level of care covered, exclusions for certain conditions, renewability, deductibles, etc.

If you are asked to advise someone about buying a long term care insurance policy, urge them to compare several policies. The potential for abuse with such a new product is great. Unclear policy language and misleading marketing practices exist as they do with many new insurance products.

As a resource, you may wish to contact a representative from your local HIICAP (Health Insurance Information Counseling and Assistance) Program. In addition to assistance from your local Area Agency on Aging, assistance is available in New York City by calling the Department for the Aging HIICAP Helpline at (212) 333-5511 and requesting an appointment. Or, call the NYS Office for the Aging’s Senior Citizens’ Hot Line at 1-800-342-9871.



# Regulations Governing Long Term Care Facilities

## STATE LICENSURE OF NURSING HOMES

It is important for Ombudsmen to understand the standards, process and agencies involved in licensing a nursing home. When complaints come to the Ombudsman Program the minimum standards contained in state law tell the consumer and the ombudsman what kind of services, care, and physical surroundings to expect. If the Program needs to intervene because a home fails to meet those standards, the standards are a guide to the residents, ombudsmen and the home as to how to comply with the law.



In 1987 Congress passed a law called the Nursing Home Quality Reform Amendments of 1987, known in shorthand as OBRA '87, since it was a part of the Omnibus Budget Reconciliation Act of 1987. This law phases in many changes in the federal requirements for nursing homes.

## Certification Requirements for Nursing Facilities(NFs)

The federal requirements for Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) are called Level A Requirements and Level B Requirements. Level B Requirements are the standards that make up the more global level A Requirements. These requirements are set by the U.S. Department of Health and Centers for Medicare and Medicaid Services (CMS).

*Among the significant changes brought about by the 1987 amendments:*

1. The elevation of residents' rights to a more important requirement within the regulatory system.
2. The new requirement for quality of care which shifts the focus of regulation to improving the quality of care for residents.





3. Focus of rules on “attaining or maintaining the highest practicable physical, mental and psychosocial well being” instead of minimum standards.

*Level A Requirements include:*

1. Resident Rights
2. Admission, Transfer, and Discharge
3. Resident Behavior and Facility Practice
4. Quality of Life
5. Resident Assessment
6. Quality of Care
7. Nursing Services
8. Dietary Services
9. Physician Services
10. Specialized Rehabilitative Services
11. Dental Services
12. Pharmacy Services
13. Infection Control
14. Physical Environment
15. Administration

Another significant change is that the requirements for the old Health Related Facilities (HRFs) are now Skilled Nursing Facilities (SNFs). This combined HRF and SNF facility is called a Nursing Facility (NF). Since NFs are now required to be able to deliver the higher skilled level of care, the nursing staff requirement has been upgraded.

### **Survey Process**

*The New York State Department of Health (SDOH) makes an unannounced annual survey. They do the survey under a contract with the CMS. Depending on the size of the home, they spend up to one week inspecting and/or surveying. In the past few years the federal survey process has changed from one that examined if a home had the proper type of personnel, and the appropriate policies and procedures in place to one that reviews the outcomes of resident care. Newer elements in the survey*

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include interviewing residents about their care, observing meal service, and observing the nursing staff pass medications to the residents.

While conducting the survey, SDOH personnel will record any violations of standards or deficiencies on a form. At the exit interview with the home's administrator, the administrator proposes how the facility will correct those problems identified. This plan of correction is recorded on the same form as the deficiencies. A time limit for corrections is set, generally 30 days, and SDOH returns and resurveys for those deficiencies. This form, is commonly called the "Survey Profile Summary".

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The new survey process devised in response to OBRA '87 is more oriented toward reviewing care outcomes for residents. The timing of the survey will now vary from the strictly annual time table to between nine and fifteen months. In addition, the ombudsman can attend the exit interview. That is the interview the survey team conducts with the nursing home administrator upon the completion of the survey.



## Facility Rating

*As a part of the annual survey profile rating system, the survey team rates each of the following areas:*

- Resident Rights
- Admission Transfer/Discharge Rights
- Resident Behavior/Facility Practice
- Quality of Life
- Resident Assessment
- Quality of Care
- Nursing Services
- Dietary Services
- Physician Services
- Specialized Rehabilitative Services
- Dental Services
- Pharmacy Services
- Infection Control
- Physical Environment





- Administration

*Each area, which has subcategories not shown, is rated as to:*

- Compliance/No deficiencies
- Substantial Compliance
- Correction Required
- Significant Correction Required
- Not in Substantial Compliance
- Immediate Jeopardy
- Substandard Quality of Care Identified

A facility that has deficiencies, 3 thru 7, they must submit a detailed Plan of Correction (POC) within 30 days. The SDOH follows up with another visit within 30 days to ensure that the deficiencies have been corrected. In another 30 days(90 days from the original visit), if deficiencies persist, all Medicaid/Medicare reimbursement for new admissions will be denied.

And, at the end of 6 months the license of the facility will be terminated and the facility will go into receivership with NYS.

### **Licensing Inspectors and Departments**

While the *New York State Department of Health* has the lead responsibility in licensing, other state and local departments of government do inspections and issue reports on which New York State acts. They are:



- Office of State Fire Marshall and its local inspectors - Fire safety code, fire alarms, evacuation plans, and water pressure.
- Local Health Department - Food storage and preparation, food service, and cleaning of dishes and equipment.

### **ENFORCEMENT IN LONG TERM CARE FACILITIES**

Ombudsmen need to understand the enforcement process. Complaints registered with the Ombudsman Program often involve a violation of either the licensure or certification standards. Given that resident care and

residents' rights are the most frequently recorded complaints, involvement with care standards and residents' rights is great. Ombudsmen should use the state and federal enforcement system to further the wishes of their clients.



### **Types of Enforcement Processes**

**R** New York State's DOH is the main actor in enforcing the state and federal requirements. Besides the annual survey and the resurveys for deficiencies, DOH can survey based on a complaint. During a complaint survey, DOH can survey the entire facility if they feel it is necessary. The surveyors record the deficiencies and plans for correction onto the same inspection reports used for the annual survey. Those documents are a matter of public record and are available for the past five years in the facility for inspection by the public.

If a facility cannot correct a deficiency after a survey or the facility has repeatedly violated the same requirement, the state has other enforcement mechanisms it can use including:

- Assessing a fine;
- Placing a monitor in the facility;
- Appointing a receiver for facility;
- Denying, refusing or revoking a license;
- Suspending a license or issuing a provisional license; and
- Publicly listing these actions in the home and through (Identify State Agency).

The goal of the nursing home inspection system is not to close down facilities but to assure that they operate safely. Enforcement experts believe that assessing fines for repeat offenders is the more effective enforcing mechanism or sanction.

Closing a facility is the last resort since residents' lives are disrupted when they are moved and beds can be difficult to find.





# Assessment and Care Planning

Each and every person in a nursing home has a right to good care under the 1987 Federal Nursing Home Reform Law (OBRA'97). The law, part of the Social Security Act, states that a nursing home must help each resident “attain or maintain” his or her highest level of well being — physically, mentally, and emotionally. To give good care, staff must assess and plan care to support each resident’s life-long patterns, current interests, strengths, and needs. Care planning conferences are a valuable forum for residents and families to voice concerns, ask questions, give suggestions, learn nursing home strategies, and give staff information (such as resident background and daily routine). This requirement in the law is vital to making sure residents receive good care.



## **RESIDENT ASSESSMENT**

Assessments gather information about the health and physical condition of a resident and how well a resident can take care of themselves. This includes assessing when help may be needed in activities of daily living (ADLs) or “functional abilities” such as walking, eating, dressing, bathing, seeing, hearing, communicating, understanding, and remembering. Assessments also should examine a resident’s habits, activities, and relationships in order to help her live more comfortably and feel at home in the facility.

The assessment helps staff be aware of strengths of the resident and also determine the reason for difficulties a resident is having. An example of where a good assessment helps: A resident begins to have poor balance. This could be the result of medications, sitting too much, weak muscles, poorly fitting shoes, or a urinary or ear infection. Staff must find out the cause of a problem in order to give good treatment. Figuring out the cause is much easier with a good assessment.

Many factors should be taken into account during the assessment. A partial list of items to be assessed includes:

- Life history, daily routine, strengths, interests, food preferences, and other personal information;
- Functional abilities including walking, dressing, using the toilet and eating;
- Physical or mental conditions that affect a resident;
- Potential for improvement;
- Communication abilities;
- Nutritional status and medications.

A thorough assessment is vital to knowing the resident so staff can care for her in a manner that enhances her quality of life. The assessment must be completed within 14 days of admission into the home, or 7 days for Medicare residents. Thereafter, an annual assessment must take place or be conducted if the resident's condition changes. Reviews are held every three months and when a resident's condition changes.

## **PLAN OF CARE**

After the assessment is completed, the information is analyzed and a care plan is developed to address all the needs and concerns of the resident. The initial care plan must be completed within seven days after the assessment. The care plan is a strategy for how the staff will help a resident every day. This care plan says what each staff person will do and when it will happen (for example, a nursing assistant will help Mrs. Jones walk to each meal to build her strength). Care plans must be reviewed regularly to make sure they work and must be revised as needed. For care plans to work, residents must feel they meet their needs and must be comfortable with them.

Care planning is an essential part of healthcare, but is often misunderstood or regarded as a waste of time. Without a specific document delineating





the plan of care, important issues are likely to be neglected. Care planning provides a “road map” of sorts, to guide all who are involved with a patient/resident’s care. The care plan has long been associated with nursing, and many people believe that it is in the sole domain of nurses. This view is damaging to all members of the interdisciplinary team, as it shortchanges the non-nursing contributors while overloading the nursing staff. To be effective and comprehensive, the care planning process must involve all disciplines that are involved in the care of this patient/resident.

### *Care Planning Conference*

The care plan is developed by an interdisciplinary team -- nurse, nurse aide, activities and dietary staff, and social worker, with critical input from the resident and/or family members. All participants discuss the resident’s care at a care plan conference to make certain that all medical and non-medical issues, including meals, activities, therapies, personal schedule, medical and nursing care, and emotional needs are agreed upon and addressed. Resident and family member concerns should be listened to by staff and addressed in the care plan. Every 90 days after the development of the initial plan, or whenever there is significant change in a resident’s physical or mental health, the care plan is reviewed. The assessment and care planning process is completed annually or when there is a significant change.

### *Good Care Plans Should*

- Be specific to that resident;
- Be followed as an important guideline for providing good care for the resident;
- Be written so that everyone can understand it and know what to do;
- Reflect the resident’s concerns and support his or her well-being;

- Use a team approach involving a wide variety of staff and outside referrals as needed;
- Assign tasks to specific staff members;
- Be re-evaluated and revised routinely.

The care planning process is never truly completed until the patient/resident is discharged from the current care setting or is deceased. The care plan needs to be fluid and changeable, as patient/resident status changes. Periodic scheduled reevaluation must take place, with changes being made as needed. Unscheduled updates should also be made as condition warrants. If the person has had a major change in a problem area which results in changes in goals and approaches, it may be easiest to resolve the problem and enter an entirely new problem, goal(s) and approaches, rather than making many changes to the existing problem. Remember the ultimate purpose of the care plan is to guide all who are involved in the care of this person to provide the appropriate treatment in order to ensure the optimal outcome during his/her stay in our healthcare setting. A caregiver unfamiliar with the patient/resident should be able to find all the information needed to care for this person in the care plan.

## **STEPS FOR RESIDENTS AND FAMILY PARTICIPATION IN CARE PLANNING**

Residents and family members have the right to be involved in the care plan conference in order to make choices about care, services, daily schedule, and life in the nursing home. Even if a resident has dementia, involve them in care planning as much as possible. They may understand and communicate at some level and help the staff to find ways to communicate and work with them. They can express when they hurt or suffer if they are actively listened to. Participating in care plan conferences is a way to be heard, raise questions, and come to a clear agreement with the facility about how the resident will be cared for.





*Before the meeting:*

- Ask staff to hold the meeting at a convenient time for you and/or your family member;
- Ask for a copy of the current care plan (if one already exists) so that you can examine each aspect thoughtfully;
- Know about or ask the doctor or staff about your or your loved one's condition, care, and treatment;
- Plan your list of questions, needs, problems, and goals; and
- Think of examples and reasons to support changes you recommend in the care plan.

*During the meeting:*

- Make sure the resident is involved and listened to carefully.
- Discuss options for treatment and for meeting your needs and preferences;
- Ask questions if you need terms or procedures explained to you;
- Be sure you understand and agree with the care plan and feel it meets your needs;
- Ask for a copy of the care plan;
- Find out who to talk to if changes in the care plan are needed; and
- Find out who to talk to if there are problems with the care being provided.

*After the meeting:*

- Monitor whether the care plan is being followed;
- Inform the resident's doctor about the care plan if he was not directly involved;
- Talk with nurse aides, staff or the doctor about the care plan; and

- Request another meeting if the plan is not being followed.

## ASSESSMENT AND CARE PLANNING IN ACTION

### A Resident's Story

*Mary lived alone for almost 20 years after her husband died. She was fiercely independent and, although frail at 87, was still able to tend her garden. Her daughter, though, began to notice that her mom was not able to remember recent events. Then, her mom forgot to turn off the stove and dinner went up in flames. Some time later, Mary was found 5 miles from her home, lost and disoriented.*

*Mary went through a battery of tests and was diagnosed with dementia. Her daughter, fearful for her mom, searched for the best nursing home. Within a month, Mary moved to Sunnyside Manor and her daughter felt great relief because her mom was safe and secure.*

*Unfortunately, her euphoric feeling was short-lived. One month after moving into the nursing home, the daughter was presented with a litany of things her mom was doing wrong. "She wandered into other resident's rooms... she became disruptive and screamed when nurse aides wanted her to go to the TV room...she tried to sneak out the back door."*

*The next time the daughter visited, Mary was tied in a chair. Staff explained to the stunned daughter that her mom was quite a problem and that today, "she hit the nurse aide." When the daughter demanded that her mom be released from the chair, staff explained that they had a right to protect themselves from her outbursts and that the only other option was to discharge her from the home.*

### Behavioral Symptoms vs. Resident as Problem

In the preceding story, Mary, the resident, was perceived as the problem. From this negative, blame-the-victim perspective, staff can do little or no constructive problem-solving to address Mary's needs. It is necessary for staff to look at the resident from a new vantage point—through Mary's





perspective. (Mary cannot tell you what is wrong. She expresses much of her distress in behavioral symptoms.)

The Assessment and Care Plan should emphasize two main points: the uniqueness of each resident and the staff's responsibility in meeting each individual resident's needs. With these points as the focus, the question can be reframed from "Why is the resident a problem?" to "What do Mary's behavioral symptoms mean (unmet need) and how can staff help her?"

Mary's symptoms included "aimless" wandering, disruptiveness, and striking other residents and staff. Restraining her will lead to decreased mobility and ability, listlessness, increased agitation, physical problems, and more work for nursing home staff. Instead of using restraints, staff can ask questions which will help find the cause of Mary's behavior and point to appropriate responses. Some potential questions follow with a plausible answer:

*Q: Why is Mary wandering?* Does Mary have a history of spending time outside? If she enjoys wandering, can staff help her do this safely? Are staff taking her outside for exercise?

*A:* Mary previously spent many hours outside taking long walks, visiting neighbors and caring for her garden. This is a life-long routine and should be continued. Staff have instead assumed that Mary should sit and watch TV. Mary had not been taken outside at all during her month at the nursing home.

*Q: Why would Mary scream?* Is there a physical reason for the behavior (pain or infection)? What types of activities did Mary enjoy before the dementia? Is the TV room too noisy?

*A:* Mary never enjoyed watching TV. She likes to look at the garden from the window in her room. Despite her dementia, she is still aware of her likes and dislikes and these should be respected.

*Q: What happened when the nurse aide was hit? Was she trying to get Mary to do something she didn't want to do? Did Mary feel threatened? Are staff trained to work with residents with dementia?*

*A: The nurse aide yelled at Mary as she approached and Mary felt threatened. It is important for the nurse aide to be gentle and soft spoken in her approach.*

### *What Should Be Done*

Most nursing home staff want to do a good job. It is important the first approach addresses the issues in a positive, non-confrontational manner. Take the following steps:

- Ask for a care plan conference;
- Make sure the right questions are asked. Use why, when, where, and how questions to help staff think of as many reasons for the behavior as possible;
- Keep the focus on the needs of the resident;
- Know the resident's rights under the law. Residents cannot be forced to leave the home without specific notice and appeal rights; physical restraints cannot be used to treat symptoms treatable by individualized care;
- Monitor implementation of the care plan and address lack of implementation immediately;
- Work closely with aides and professional nurses to orient them to the resident;
- Make sure the resident's doctor is aware of and supportive of the resident's care plan; and
- Request outside consultation, if necessary.







# End of Life Care

When a resident is appropriate for end of life care varies. Death comes in its own time; in its own way.<sup>8</sup>

There may be an obvious time, such as after a major medical event, when end of life care is needed for a nursing home resident. Other times, one can see a pattern of subtle changes. A resident may be experiencing a gradual decline in his/her clinical status over a series of weeks, or months. Generally recognized signs that end of life care is appropriate are as follows: weight loss, difficulty swallowing, difficulty breathing, weakness, and changes in ability to eat, dress, bathe or use toilet facilities independently. When a resident appears to be in the advanced stages of illness and/or general debilitation, end of life care is appropriate.

In many nursing homes in New York State, contracts with Hospice organizations are in place to allow Hospice workers to provide care with nursing home staff for those residents during their end of life phase. Considered to be the model for quality, compassionate care at the end of life, hospice care involves a team oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is extended to the patient's loved ones as well. At the center of hospice care is the belief that each of us has the right to die pain free and with dignity, and that our families will receive the necessary support to allow us to do so.<sup>9</sup> Hospice programs provide staff that are expert in symptom management and pain control. Hospice care is provided by a licensed hospice provider. The cost for care is covered by Medicare, as well as many insurance policies. The determination to admit a resident to Hospice care within the nursing home is made by the patient and family, clinical staff including facility and Hospice staff, and the patient's physician and/or medical directors.

## RESPONSES OF FRIENDS AND FAMILY

As the resident enters what appears to be an end of life phase, this may signal the beginning of anticipating the death of their loved one, which can be followed by a variety of reactions.

Friends and family members may fear the death of loved one and may resist the idea that this is part of their loved one's natural life process, and not a change brought on by nursing home staff neglect. Depending on each person's life experience, they may not understand that there is care available to make their loved one comfortable and have good quality of life for whatever time he or she has. Typical reactions are anger, anxiety and grief.

Friends and family may misunderstand when their loved one's appetite diminishes, as well as their desire to drink liquids. This may also generate anger at staff, and/or stimulate discussion regarding artificial nutrition and hydration.

If changes in a loved one's physical status were gradual, friends and family may be more prepared for the inevitability of their loved one's death. If advance directives were discussed by the resident with his/her loved ones prior to this end of life phase, decisions regarding artificial nutrition and hydration can be made much simpler.

At this point in time, nursing homes do not have a legal obligation to contract with Hospice care providers to allow Hospice care in facilities. For a variety of reasons, not all nursing homes elect to have Hospice care available to their residents regardless of the availability of a licensed Hospice care provider. "Comfort Care" programs are programs designed by nursing home facility staff to provide end of life care. These programs vary in design and content from facility to facility. Comfort Care programs are not hospice care programs.





## RESOURCES

### Nursing Homes — Getting Good Care There

A companion training guide for this book was published by the National Ombudsman Resource Center. The guide contains tips on training as well as master overheads and handouts. Contact Julie Meashey, Information Specialist at the National Citizen's Coalition for Nursing Home Reform (NCCNHR).

Tel: 202 332-2275 x115

Email: [jmeashey@nccnhr.org](mailto:jmeashey@nccnhr.org)



### Nursing Home Care Plans: Getting Good Care

Video on resident assessment and care planning with a discussion guide produced by the American Association of Retired Persons in 1999. Contact NYS LTCOP for a copy.



### Using Resident Assessment and Care Planning as Advocacy Tools: A Guide for Ombudsmen and Other Advocates

Booklet published by the National Ombudsman Resource Center. Contact Julie Meashey, Information Specialist at the National Citizen's Coalition for Nursing Home Reform (NCCNHR).

Tel: 202 332-2275 x115

Email: [jmeashey@nccnhr.org](mailto:jmeashey@nccnhr.org)



*Available from the Centers for Medicare and Medicaid Services (CMS)*

Resident Assessment Instrument Information (forms, manuals, requirements)

Web: <http://www.cms.hhs.gov>



## MODULE 4 ENDNOTES

- 1 Adapted from training materials from the State of Michigan.
- 2 Adapted from training materials from the States of Ohio and Mississippi.
- 3 Adapted from training materials from the State of Ohio.
- 4 Adapted from training materials from the State of Ohio.
- 5 Midlife and Older Americans with Disabilities: Who Gets Help? AARP, A Chartbook, Public Policy Institute 1998.
- 6 Adapted from training materials from the State of Virginia.
- 7 Karnes, Barbara. *Gone From My Sight: The Dying Experience*.
- 8 National Hospice Foundation. *Hospice Care: A Consumer's Guide to Selecting a Hospice Program*.

